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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 922

Introduced by Assembly Member Monning

February 18, 2011

An act to amend Section 1368.02 of, and to add Division 115 (commencing with Section 136000) to, the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 922, as amended, Monning. Office of Patient Advocate.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law creates within the Department of Managed Health Care an Office of Patient Advocate to assist enrollees with regard to health care coverage, which is headed by a patient advocate recommended to the Governor by the Business, Transportation and Housing Agency. The Office of Patient Advocate is responsible for, among other things, developing educational and informational guides for consumers, compiling an annual publication of a quality of care report card, and rendering advice and assistance to enrollees. The annual budget of the Office of Patient Advocate is separately identified in the annual budget

request of the department. *The California Health and Human Services Agency consists of, among others, the State Department of Health Care Services, the State Department of Mental Health, the State Department of Public Health, and the State Department of Social Services.*

This bill would transfer the Office of Patient Advocate from the Department of Managed Health Care to ~~instead operate as an independent state entity, and~~ *the California Health and Human Services Agency. The bill would* delete the requirement that the patient advocate be recommended to the Governor by the Business, Transportation and Housing Agency. The bill, *effective January 1, 2013,* would add additional duties and responsibilities to the existing duties of the Office of Patient Advocate with regard to providing outreach and education about health care coverage to consumers. The bill, *effective January 1, 2013,* would authorize the office to contract with community organizations, *subject to specified requirements,* to provide those services and would *also* require the office to adopt certain standards and procedures regarding those organizations. The bill, *effective January 1, 2013,* would require specified state agencies to report to the office regarding consumer complaints submitted to those agencies by individuals with complaints about their health care coverage. The bill would provide that funding for the actual and necessary expenses of the office shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund, to be based on the number of covered lives in the state that are covered by plans or insurers, as determined by the Department of Managed Health Care and the Department of Insurance, in proportion to the total number of covered lives in the state. The bill would establish the Office of Patient Advocate Trust Fund for those purposes and would make moneys deposited into that fund available for purposes of administering the program, subject to appropriation by the Legislature. The bill would also authorize the office to apply to the federal government for moneys to fund the office and require the office to request from the federal government specified grant moneys.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1368.02 of the Health and Safety Code is amended to read:

1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

SEC. 2. Division 115 (commencing with Section 136000) is added to the Health and Safety Code, to read:

DIVISION 115. OFFICE OF PATIENT ADVOCATE

136000. (a) (1) There is hereby transferred from the Department of Managed Health Care the Office of Patient Advocate ~~to operate as an independent entity within state government, which shall be known and may be cited as the Gallegos-Rosenthal Patient Advocate Program,~~ *to be established within the California Health and Human Services Agency,* to represent the interests of enrollees served by health care service plans regulated by the Department of Managed Health Care, insureds covered by health insurers regulated by the Department of Insurance, and individuals who receive or are eligible for other health care coverage in California, including coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program. The goal of the office shall be to help those enrollees, insureds, and individuals to secure health care coverage to which they are entitled under the law. *Notwithstanding any provision of this division, each regulator and public program shall retain its respective authority to resolve complaints, grievances, and appeals.*

(2) The office shall be headed by a patient advocate appointed by the Governor. The patient advocate shall serve at the pleasure of the Governor.

(b) (1) The duties of the office shall include, but not be limited to, all of the following:

(A) Developing educational and informational guides for consumers describing their rights and responsibilities, and informing them on effective ways to exercise their rights to secure health care coverage. The guides shall be easy to read and understand and shall be made available in English and other threshold languages, using an appropriate literacy level, and in a culturally competent manner. The informational guides shall be made available to the public by the office, including being made accessible on the office's Internet Web site and through public outreach and educational programs.

(B) Compiling an annual publication, to be made available on the office's Internet Web site, of a quality of care report card, including, but not limited to, health care service plans.

(C) Rendering advice and assistance to consumers regarding the filing of complaints, grievances, and appeals, including appeals of denials of care with the health care coverage program denying eligibility, and appeals with the internal appeal or grievance process of the health care service plan, health insurer, group health plan, or other county or state health care program involved, and provide information about any external appeal process.

~~(D) Providing direct assistance to consumers, if necessary, including assistance in filing complaints, grievances, or appeals with the appropriate regulator or public program.~~

~~(E)~~

(D) Rendering advice and assistance to consumers with problems related to health care services, including care and service problems and claims or payment problems. ~~Explaining how to resolve these problems and providing direct assistance, if needed, including assistance in filing complaints, grievances, or appeals with the appropriate regulator or public program.~~

~~(F) Advising consumers on problems related to mental health parity and coverage for substance abuse treatment, consistent with existing state and federal law, including assistance in filing complaints, grievances, or appeals with the appropriate regulator or public program.~~

~~(G)~~

(E) Making referrals to the appropriate state agency regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of consumers.

~~(H)~~

(F) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsperson programs.

(2) The office shall employ necessary staff. The office may employ or contract with experts when necessary to carry out the functions of the office. The patient advocate shall make an annual budget request for the office which shall be identified in the annual budget act.

(3) The office shall have access to records of the Department of Managed Health Care and the Department of Insurance,

including, but not limited to, information related to health care service plan or health insurer audits, surveys, and enrollee or insured grievances.

(4) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

(c) ~~The~~ *Commencing on January 1, 2013, the* office shall also do all of the following:

(1) Receive and respond to all ~~telephonic, electronic, and in-person~~ inquiries, complaints, and requests for assistance from individuals concerning all health care coverage available in California.

(2) Provide outreach and education about health care coverage options, including, but not limited to:

(A) Information regarding applying for coverage; the cost of coverage; renewal in, and transitions between, health coverage programs; and education about how to navigate the health care arena, including what health care services a plan or insurer offers or provides, how to select a plan or insurer, and how to find a doctor or other health care provider.

(B) Information and referral for all types of payers, including public programs such as Medi-Cal, Healthy Families, and Medicare; private coverage, including employer-sponsored coverage, self-insured plans, unsubsidized Exchange coverage, and Exchange coverage with tax subsidies or tax credits; and other sources of care, such as county services, community clinics, discounted hospital care, or charity care.

(3) Educate consumers on their rights and responsibilities with respect to health care coverage.

(4) Advise and assist consumers with resolving problems with obtaining premium tax credits under Section 36B of the Internal Revenue Code.

(5) Provide explanations to consumers on resolving problems related to health care services, and, if necessary, provide direct assistance to consumers in filing complaints, grievances, or appeals with the appropriate regulator or public program.

(6) Advising consumers on problems related to mental health parity and coverage for substance abuse treatment, consistent with

existing state and federal law, including assistance in filing complaints, grievances, or appeals with the appropriate regulator or public program.

(d) ~~The~~ *Commencing on January 1, 2013, the* office may contract with community-based consumer assistance organizations to assist in any or all of the duties of subdivisions (b) and (c) *in accordance with Section 19130 of the Government Code*.

(e) (1) ~~The~~ *Commencing on January 1, 2013, the* office shall collect, track, quantify, and analyze problems and inquiries encountered by consumers with respect to health care coverage, including, but not limited to, the complaints reported to the network of health consumer assistance organizations and the agencies under subdivision ~~(n)~~ *(m)*. The office shall publicly report its analysis of these problems and inquiries at least quarterly on its Internet Web site.

(2) The office shall track, analyze, and publicly report on complaints reported to the office under subdivision ~~(n)~~ *(m)* according to the nature and resolution of the complaints ~~and~~, including, but not limited to, the ~~health status,~~ age, race, ethnicity, language, geographic region, ~~gender, gender identity, gender expression, or sexual orientation~~ *and gender* of the complainants in order to identify the most common types of problems and the problems faced by particular populations, including any health disparity population.

(3) The office shall track, analyze, and report on those complaints by all of the following:

(A) Health insurer or health care service plan.

(B) ~~Health status, age~~*Age*, race, ethnicity, language preference, geographic region, ~~gender, gender identity, gender expression, and sexual orientation~~ *and gender*.

(C) The type of health care coverage program *and its respective regulator*.

(D) The timeliness of resolution of complaints.

(4) In analyzing and reporting complaints, the office shall take into account the number of individuals enrolled by each health insurer or health care service plan and in each health care coverage program.

(f) ~~In~~ *Commencing on January 1, 2013, in* order to assist consumers in navigating and resolving problems with health care coverage and programs, the office shall do the following:

(1) Operate a HealthHelp toll-free telephone hotline number that can route callers to the proper regulating body or public program for their question, their health plan, or the consumer assistance program in their area and provide interpreters for limited-English-proficient callers.

(2) Operate a HealthHelp Internet Web site, other social media, and up-to-date communication systems to give information regarding the consumer assistance programs.

(g) ~~The~~ *Commencing on January 1, 2013, the* office and any local community-based nonprofit consumer assistance programs with which the office contracts shall include in their mission assistance of, and duty to, health care consumers. Contracting consumer assistance programs shall have experience in the following areas:

(1) Assisting consumers in navigating the local health care system.

(2) Advising consumers regarding their health care coverage options and helping consumers enroll in and retain health care coverage.

(3) Assisting consumers with problems in accessing health care services.

(4) Serving consumers with special needs, including, but not limited to, consumers with limited-English language proficiency, consumers requiring culturally competent services, low-income consumers, consumers with disabilities, consumers with low literacy rates, and consumers with multiple health conditions, including behavioral health.

(5) Collecting and reporting data on the categories of populations listed in subdivision (e), including subgroup categories of race, ethnicity, language preference, gender, ~~gender identity, gender expression, and sexual orientation,~~ and types of health care coverage problems consumers face.

~~(h) Consumer assistance programs that contract with the office to provide direct consumer assistance shall qualify as navigators pursuant to paragraph (1) of subdivision (*l*) of Section 100502 of the Government Code.~~

~~(i) The~~

(h) Commencing on January 1, 2013, the office shall collect and report data to the United States Secretary of Health and Human Services on the categories of populations listed in subdivision (e),

including subgroup categories of race, and types of problems and inquiries encountered by consumers.

~~(j) The~~

(i) Commencing on January 1, 2013, the office shall develop protocols, procedures, and training modules for organizations with which it contracts. The office shall implement and oversee a training program with continuing education components for organizations with which it contracts.

~~(k) The~~

(j) Commencing on January 1, 2013, the office shall adopt standards for organizations with which it contracts regarding confidentiality and conduct. The office shall have the power to revoke the contract of any organization that violates these standards and shall include a clause reserving that power in every contract entered into with such an organization.

~~(*l*) The~~

(k) Commencing on January 1, 2013, the office may contract with consumer assistance programs to develop a series of appropriate literacy level and culturally and linguistically appropriate educational materials in all threshold languages for consumers regarding health care coverage options and how to resolve problems. These materials shall be made available to all consumer assistance programs and on the Internet Web site of the office.

~~(m) The~~

(l) (1) Commencing on January 1, 2013, the office shall develop protocols and procedures for the resolution of consumer complaints and the establishment of responsibility or referral, as appropriate, with regard to the following agencies:

~~(1)~~

(A) The federal Department of Labor regarding employee welfare benefit plans regulated under ERISA.

~~(2)~~

(B) The Health Insurance Counseling and Advocacy Program as provided in Section 9541 of the Welfare and Institutions Code and, as appropriate, the federal Centers for Medicare and Medicaid Services regarding the Medicare Program.

~~(3)~~

(C) The Department of Managed Health Care regarding coverage under health care service plans regulated under Chapter 2.2 (commencing with Section 1340) of Division 2.

~~(4)~~

(D) The Department of Insurance regarding policies of health insurance regulated under the Insurance Code.

~~(5)~~

(E) The State Department of Health Care Services regarding the Medi-Cal program.

~~(6)~~

(F) The Managed Risk Medical Insurance Board regarding the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code).

~~(7)~~

(G) The Exchange regarding coverage through the Exchange.

(2) The protocols and procedures shall include all of the following:

(A) A procedure for the referral of complaints and grievances to the appropriate regulator or public program for resolution by the relevant regulator or public program.

(B) A process for reporting to the appropriate regulator and public program those complaints and grievances that were received and resolved without filing a complaint or grievance with the regulator or public program.

~~(n) The~~

(m) Commencing on January 1, 2013, the Department of Managed Health Care, the Department of Insurance, the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and the Exchange shall report *only* data and other information *in its possession* to the office regarding consumer complaints submitted to those agencies, including, but not limited to, the nature of the complaints, the resolution of the complaints, the timeliness of the resolution, and the ~~health status,~~ age, race, ethnicity, language, geographic region, ~~gender, gender identity,~~

~~gender expression, or sexual orientation~~ *and gender* of the complainants, in a format and manner to be specified by the office. This information shall be reported according to the particular health insurer or health care service plan involved. *This information shall also be reported according to the source of coverage, including employer-based coverage, individual coverage, or specific public program coverage, including Medicare, Medi-Cal, the Exchange, or other publicly funded coverage.*

~~(o)~~

(n) For purposes of this section, the following definitions shall apply:

(1) "Consumer" or "individual" includes the individual or his or her parent, guardian, conservator, or authorized representative.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(3) "Group health plan" has the same meaning *as* set forth in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91).

(4) "Health care" includes behavioral health, including both mental health and substance abuse treatment.

(5) "Health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345. Health care service plan includes "specialized health care service plans," including behavioral health plans.

(6) "Health insurance" has the same meaning as set forth in Section 106 of the Insurance Code.

(7) "Health insurer" means an insurer that issues policies of health insurance.

(8) "Office" means the Office of Patient Advocate.

(9) "Threshold languages" ~~are languages spoken by at least 20,000 or more limited-English-proficient health consumers residing in California.~~ *shall mean Medi-Cal threshold languages.*

136020. (a) The Office of Patient Advocate Trust Fund is hereby created in the State Treasury, and, upon appropriation by the Legislature, moneys in the fund shall be made available for the purpose of this division. Any moneys in the fund that are unexpended or unencumbered at the end of the fiscal year may be carried forward to the next succeeding fiscal year.

(b) The office shall establish and maintain a prudent reserve in the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on moneys that have been deposited in the fund shall be retained in the fund and used for purposes consistent with this division.

136030. (a) In addition to the moneys received pursuant to subdivision (d), funding for the actual and necessary expenses of the office in implementing this division shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care and the Healthy Families Program, as determined by the Department of Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state.

(d) In addition to moneys received pursuant to subdivision (a), the office may receive funding as follows:

(1) The office may apply to the United States Secretary of Health and Human Services for federal grants.

(2) The office shall apply to the United States Secretary of Health and Human Services for a grant under Section 2793 of the federal Public Health Service Act, as added by Section 1002 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(3) To the extent permitted by federal law, the office may seek federal financial participation for assisting beneficiaries of the Medi-Cal program.

(e) All moneys received by the Office of Patient Advocate shall be deposited into the fund specified in Section 136020.

O